Most Frequently Asked Questions
Revised Nursing Facility Level of Care Services

1) Why is the Department making this change?

Currently, an applicant must meet three (3) out of (9) stated criterion in order to qualify for Nursing Facility level of care. Administrative Regulation 907 KAR 1:022 has been amended and now states that an individual, in order to qualify for Medicaid payment for nursing facility care, must only meet a combination of at least two (2) out of nine (9) care need categories.

Additionally, the Department is also adding a clause addressing those residents who may have resided in an institution for eighteen (18) months and who no longer meet two of the nine level of care requirements. For that particular segment of residents that may be denied, if their attending physician believes that a transfer from the institution would be detrimental to the physical, emotional or mental health of the resident, the physician may submit a statement to that effect for review by the Department. If approved, the resident may continue to reside in the institution without meeting the level of care criteria and will be reevaluated every six (6) months.

2) When is this change effective?

This change is effective January 30, 2004.

3) What recipients will be affected by this change?

Nursing facility residents, Home and Community Based Waiver recipients and anyone applying for these types of services.

4) What about those recipients in current appeal status?

For those residents who are currently in appeal status, this new criteria requirement will now be used for evaluation of their level of care determination.

5) What about those recipients denied level of care since April 4, 2003?

For those recipients who were denied level of care under the former criteria, the Department will be mailing notification to these individuals that the criteria required to meet level of care has changed and they may choose to reapply for services if they so desire.

6) Does the resident have to be in Medicaid payment status for the full eighteen (18) months of consecutive institutionalization, in order to qualify for "transfer trauma"?

No, the institutionalization period applies to the date of admission of the resident to the facility, regardless of payment status.

7) How would an application for "transfer trauma" affect a resident's rights concerning denial of level of care?

A resident may still appeal denial of the decision on whether the level of care criteria has been met while applying for "transfer trauma".

8) What providers will be impacted by this change?

Nursing Facilities, Model Waiver II, Home and Community Based Waiver Services, and Adult Health Day Care providers may be impacted by this change.